

PATIENT 60 YEARS OLD WITH POST MENOPAUSAL METRORRHAGIA AND FETID LEUCORRHEA.

Saadi Hanane, Chahrazed Bouchikhi

Department of gynaecology and obstetrics, University Hospital of Fez, Morocco

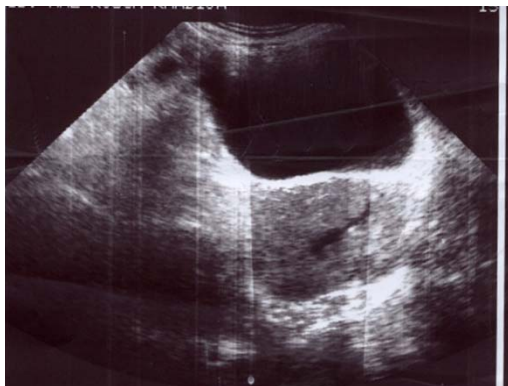
Author of correspondence:

Dr. SAADI HANANE, Av lalla hasnae, Residence Moulay Ismail appartment N17

Fez 30000, Morocco ; E Mail: saadihanane1@yahoo.fr; Tel: 00212 71358276 – 00212 35944165

CLINICAL PRESENTATION : Patient of 60 years old, big multipara, she had as family antecedents a husband treated for pulmonary tuberculosis five months ago. She was hospitalized for post menopausal metrorrhagia associated to fetid leucorrhoea since 4 months without respiratory signs. The general state of the patient has changed with no encoded fever. The clinical exam found out a faded patient, the fetid leucorrhoea and an uterus of normal size.

A pelvic echographia showed:



QUESTIONS:

- 1 - Describe the picture
- 2 - What is your diagnosis?
- 3 - Based upon clinical and radiological data what is your therapeutic attitude?

ANSWERS:

- 1 - The pelvic echographia revealed an uterus of 45 mm size with an hypoechogenous picture in intra uterine which suggests an hematometrium.
- 2 - A neo of the endometrium
- 3 - An hysteroscopy showed atrophic and hypertrophic areas of the endometrium.

Considering the patient's age post menopausal metrorrhagia a vaginal hysterectomy has been realized. Anatomopathologic study showed a chronic endometritis which highlighted an epithelio-giganto-cellular granuloma of Langhans type B, surrounded by a lymphocitary crown more or less thicker spotting out a tuberculosis of the endometrium. (Fig 1)

The patient was treated by anti-bacillary drogues 2RHZ /4RH (R: rifampicin 10mg/Kg, H: isoniazide 5 mg/Kg and the Z: pyrazinamide 25 mg/Kg), triple therapy for two months, followed by rifampicin and isoniazid dual therapy for four months. The evolution was good under treatment.

DISCUSSION :Tuberculosis is considered a public health problem either in developing or industrialized countries (1). Several factors are involved in the variation of this affection essentially including the immunodepression caused by the acquired immunodeficiency syndrome (AIDS) (2). The pelvic localization is from 6 to 10 % (3). Endometric affection is stated in the third rank after tubal cervical localization.

They are mainly noticed in endemic countries. It affects women in genital activity period between 20 and 35 years (4).

The pathogenic Agent is the Bacillus of Koch (BK): mucobacterium Tuberculosis human type exceptionnaly bovin (4).

Endometrial Localization is a possible complication of a previous a parenchymatous pleuropulmonary tuberculosis with an hematogenous contamination. The clinical diagnosis is difficult. There is a functional clinical latency with a normal general and gynecological exam (5).

The disease shows by amenorrhoea (6), pelvic pains, dyspareunia, leucorrhoea, a vaginal hydrorrhoea, diarrhea or a constipation,. The pelvic palpation can underline a shout of douglas, a painful uterus during pressure and the mobilization.

We describe then several clinical shapes:

- **Completely asymptomatic shapes:** the diagnosis is fortuitous while undergoing a gynecological exploration especially for the infertility check up.

- **Shapes appearing by amenorrhoea** that can be primary or secondary according to the age of burst. They are related to the synechia uterine being able to be objectified by the hysterosalpingographia or hysteroscopy. The diagnosis is put following the histologic analysis of a sample of the endometrium.

- **Hemorrhagic Shapes:** by the endometrium affection that is sometimes hypertrophic, the diagnosis is put following the analysis of a curettage product or to a hysterectomy done for menometrorrhagia.

- **Associated peritoneal shapes** : realizing an endometrial tuberculosis and bilateral tubal associated to a pelviperitonitis fibrocasicous (5,6).

The biology is not specific. The pelvic echographia can reveal an associated annexial affection. The hysterosalpingographia is of an important interest while showing sequellar pictures in glove finger showing synechia, but if it is normal, it doesn't eliminate the diagnosis. It should be practised away from shapes of acute infection. The thoracic x-ray in search of signs of pleuro-pulmonary affection. Without prepared abdomen sometimes shows ganglionic calcifications.

Intra-venous Urographia (UIV): looking for an associated urinary affection encountered in half of the cases (4). The coelioscopy allows to have the exam of extension, the test to the methylene bleue to appreciate tubal permeability as well as biopsies and cytological sample. Biopsic Curettage of the endometrium performed three days before menstrua while tubercular follicles are most typical. Biopsied fragments allow the bacteriological and histological analysis and, ensure diagnosis (4).

Histologic exam confirms the diagnosis by the presence of gigante-cellular epithelioid granuloma associated or not to a caseous necrosis discovered either during endometrium biopsy on a piece of exeresis (7).

Endometrium tuberculosis complications are dominated by primary or secondary barrenness following the uterine synechia.

In case of pregnancy, endometrium tuberculosis can trigger spontaneous abortions, the extra-uterine pregnancies and the premature childbirths, with risk of neonatal affection if the disease is evolutionary.

All proven tuberculosis must be treated medically. The association of several antituberculars is essential. Among the main anti-bacillaries: Rifampicine, Isoniazide, Pyrazinamide, Ethambutol, Isoniazide, thiacetazone... administred during six to twelve months with renal, hepatic and ophthalmic surveillance.

Surgical indications decreased; performed especially on annexial masses resisting to medical treatments, to relapses of endometrium tuberculosis after one year of treatment and the endoscopic cure of synechia in order to restore menstruations.

REFERENCES

[1] Nistal de Paz F, Herrero Fernandez B, Perez Simon R, Fernandez Perez E, Nistal de Paz C, Ortoll Battle P et al. Pelvic-peritoneal tuberculosis simulating ovarian carcinoma: report of three cases with elevation of the CA 125. Am J Gastroenterology 1996; 91: 1660-1.

[2] Panaskaltsis TA, Moore DA, Haidopoulos DA, McIndoe AG. Tuberculosis peritonitis: part of the differential diagnosis in ovarian cancer: case report. Am J Obstet Gynecol 2000; 182: 740-2.

[3] Shafer RW, Kim DS, Weiss JP et al. Extrapulmonary tuberculosis in patients with human immunodeficiency virus infection. Medecine 1991;70:384-97.

[4] Taleb Ahmed L ; Bouchetara K et Bouteville C. la tuberculose génitale de la femme. EMC. (Paris-France), Gynécologie, 490 A 10, 7-1989, 13p

[5] DE BRUX J. Histopathologie gynécologique.- Masson et Cie, éd., Paris 1981

[6] NETTER A : les symphyses tuberculeuses de l'utérus- REV.obstétrique.,1965 ;60 : 29-55.

[7] Grosset J. Place des examens microbiologiques et anatomopathologiques dans la décision diagnostique et thérapeutique. Med Mal Infect 1995;25:327-33.

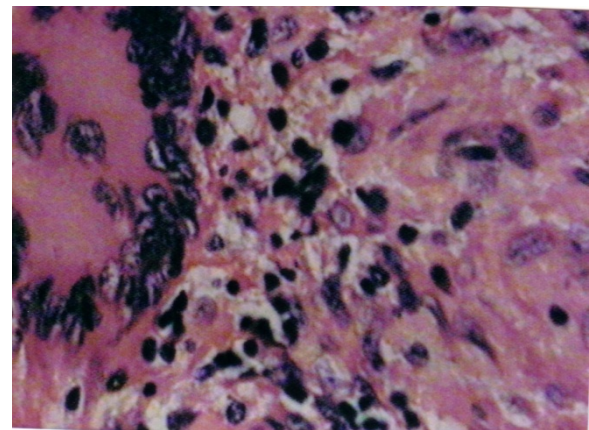


Figure 1 Multinucleated giant cell (arrow). Caseous necrosis.